MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Thursday, February 16, 2006
9:00 AM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Thursday, February 16, 2006, at 9:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair, Senators Austin Allran, Janet Cowell, Charlie Dannelly, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Bob England, Carolyn Justice, Edd Nye, and Fred Steen. Advisory member, Senator Larry Shaw, was also present.

Kory Goldsmith, Lisa Hollowell, Ben Popkin, Shawn Parker and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order, welcoming members and guests. He asked for a motion to approve the minutes from the January 26th meeting. Representative Earle made the motion and the minutes were approved.

Leza Wainwright, Deputy Director of the Division on Mental Health, Developmental Disabilities and Substance Abuse Services, reviewed the new and modified service definitions for individuals with mental illness and children with emotional disturbances. (See Attachment No. 2) She stated that the new service definitions would go into effect March 20, 2006 because according to CMS requirements, the definitions have to be implemented in the same quarter in which they are approved. Two new services offered to individuals with any disability and of any age, are diagnostic assessment and mobile crisis. Ms. Wainwright gave a detailed explanation of each of the new services. When answering specific questions regarding mobile crisis, Ms. Wainwright said that mobile crisis was an agency-based service. The LME reviews the agency to determine if it meets the requirements to do mobile crisis. She said the crisis teams are not available in all areas because it is not currently a Medicaid service but would be effective March 20. The Secretary of DHHS can grant an LME permission to offer mobile crisis services when that LME cannot find the service through an alternate provider. There was concern that there would be gaps in service across the State and that $120 per hour would not be sufficient to support a crisis unit in a non-urban setting. She said the amount paid per hour could be revisited within 6 months if necessary and she offered to get a list of agencies already endorsed to provide the mobile crisis service.

Ms. Wainwright explained that the crisis team would be a first responder for an individual that was new to the system and not affiliated with a provider program. If a person already has a service provider, that provider is the first responder. Members of the committee expressed concern that law enforcement officers were often tied up for hours

at a time with an individual in a crisis situation. It was also noted that many of the credentialed professionals do not accept Medicaid consumers making it difficult for providers to find staff. Ms. Wainwright said that Dr. Lancaster, with the Division, chairs a group looking at ways at the State level to make psychiatry less of a financial burden for providers and insure that that resource stays available. She also said that there was a pilot program in Wake County to create a partnership between law enforcement and MHDDSA professionals.

Continuing, Ms. Wainwright said the Community Support service for children and adults with MH/SA issues was expected to be the most common service used by people meeting the target population definition. This service creates the person centered plan and the crisis plan. The service serves as a platform for the delivery of evidence based practices. She also explained the Intensive In-Home service, Multi-Systemic Therapy for children ages 7 to 17 and Day Treatment for children. She said services were not designed to overlap unless a child transitions from one service to another and that clinicians would likely change during this process. There was concern that communication with multiple parties while moving through different services was stressful to family members and one goal should be to create a system that would alleviate this situation. In discussion of the Day Treatment service for children, Ms. Wainwright said children were treated in a group setting in a licensed facility. An educational component is offered within that setting along with treatment for 3 hours, 2 days a week that is billed at $31.25 per hour. Ms. Wainwright was asked if CMS had approved rates for facility based crisis units for children in other states. She offered to get the information for the committee. She was then asked if the new service definitions allowed an LME or provider to offer a 23-hour chair to a child. She answered that the service was billable in a hospital setting but not by any other service provider. Members were also interested in knowing if there was still a plan to have community based crisis units throughout the State. Mr. Moseley, Director of MHDDSAS, said the Department was working with the NC Hospital Association to try to solidify in-patient capacity in communities where local hospitals operate in-patient units. CMS approved a State Medicaid Amendment that increases the in-patient rates at local hospitals. He also said that there was still interest in looking at the development of crisis facilities where it is needed as a safety net locally in order to decrease the utilization of the State psychiatric hospitals. He was asked to provide a list of local hospitals in communities across the State that offer in-patient involuntary and in-patient voluntary capacity, a list of the current availability of crisis units, and rates for the various services. Three services eliminated for children include: Facility Based Crisis Service for Children, CBS for all persons with disabilities, and Stand Alone Case Management for mental health and substance abuse. The latter two services are being replaced by the comprehensive service of Community Support, Intensive In-Home, and Multi-Systemic Therapy.

Next, for adults, Ms. Wainwright explained that the Community Support Team was a more intense service than Community Support. It serves as a clinical home and first responder. Medicaid will now reimburse the certified Peer Support Specialist staff position. The reimbursement rate on this service is $16.52 per 15-minute unit. Community Support Teams have been structured to function like “ACTT lite” in rural areas where it is not financially viable to have Assertive Community Treatment Team (ACTT). She said that ACTT was an evidence-based best practice service with a

Master's level qualified team leader. ACTT is designed to meet 100% of the treatment needs of the consumers served. Eighty percent of service is delivered face-to-face. ACTT is paid for four contacts per month with each contact being paid at the rate of $323.98. All of these services are designed to physically go to the consumer. Psychosocial Rehabilitation is a physical licensed setting. This service is designed to increase functioning and promote independent living, 5 hours a day, 5 days and week. The reimbursement rate for this service, which is a group service, is paid on a 15-minute unit basis of $2.34 per person. The Secretary of DHHS has the authority to approve service delivery so the LME can create an ACTT if there is not one in a community and it is financially feasible. It was suggested that a matrix showing child and adult services for each LME be provided to members. The Co-Chair suggested that members consider a State supplement to providers in order to retain the staff needed to continue these highly specialized services. The final service among the new and modified Service Definitions for adults is Facility Based Crisis. It is an intensive residential service, limited to 15 days and an alternative to hospitalization. CMS did not approve this mental health service for children.

Ms. Wainwright then addressed the requirements of the agencies for service delivery. All agencies will be directly enrolled with DMA and are required to achieve national accreditation within 3 years of enrollment. All new services have a Person Centered Plan. All services are subject to a periodic utilization review. She said that the new services would be provided to consumers who are Medicaid eligible based on established medical necessity criteria and individuals who receive State funded services that are subject to the target population. Reviewing the funding for child mental health, Ms. Wainwright said that there was $53.7 million in State funds and non-Medicaid Federal dollars. $5.3 million is reserved for non-UCR, leaving $50 million to pay on a per unit of service basis for new and existing services. $16.5 million of that money must cover room and board for Medicaid and non-Medicaid children in residential placement and $150,000 was budgeted for homeless services. Adult mental health has $59.9 million appropriated with $9.7 million reserved for non-UCR and $1.8 million earmarked for individuals living in Adult Care homes. The total amount available for new and existing services is $48.4 million with $793,000 earmarked for homeless services. Members asked if the funding for the homeless was adequate. Ms. Wainwright said that was not the maximum amount that could be used for services but rather money that has to be used for those services because it is a specific Federal grant. MHDDSAS delivers the treatment costs for services and there is a Federal grant managed through the Department to address the housing needs for individuals with disabilities. Most LMEs have housing coordinators who work to increase housing availability and the Department has partnered with the NC Housing Finance Agency using one million dollars of the MH Trust Fund to provide rental assistance for 10 years for individuals with disabilities. Ms. Wainwright was also asked if there were records showing where people in hospitals were being released and if they tracked where individuals are obtaining services once they are in the community. She said the data system does not have an actual address but the system does target a location and it targets homeless shelters. Ms. Wainwright said it was difficult to track individuals staying 3 to 7 days, but those staying 30 days or longer could be tracked. She was asked to track those individuals over the last 2 months to see where they go once they are released from the hospitals and where they come from before being admitted.

Legislative staff was requested to chart who is eligible for Medicaid services and who is not and to also see what the State policy is on homelessness.

Next, Senator Nesbitt asked panelists to give their comments on barriers, challenges and recommendations to developing service capacity for mental health services. The panelists were: Becky Faucette, a family member of an adult with mental illness – (Attachment No. 3); Charles Davis, Director, NC Mentor – (Attachment No. 4); Anita Harrison, a parent of a child with a mental illness – (Attachment No. 5); and Tisha Gamboa, a consumer of mental health services and Executive Director of the NC Mental Health Consumers' Organization.

Barriers and challenges listed by the panelists included:

- Transition is difficult as services are divested to private providers
- Clients falling through cracks who do not meet the criteria for a specific definition
- Less than one third of those seeking mental health treatment are Medicaid eligible
- There are not enough psychiatrists in the system
- State only spends approximately $400 per year, per person
- State credentialing rules can restrict availability of services
- Service definitions restricting access to service by requiring 2 clinicians for Diagnostic Assessment
- State needs to set training expectations and let providers do their own training
- Trouble accessing system – Who do you call?

Recommendations included:

- Sufficient funding for quality services
- Sufficient funding for crisis services in communities to reduce hospitalization
- Enact parity legislation requiring health insurers to cover mental health services
- Address issue of non-Medicaid target population – establish ongoing funding streams
- Reduce duplication and increase statewide policies and interpretations for administrative issues
- Ensure consumers have free and informed choice of providers for all services
- Need array of local service providers with competent staff and easy access

Continuing, Senator Nesbitt asked the substance abuse services panelists to come forward with their comments regarding barriers, challenges and recommendations. Panelists included: Margaret Stargell, CEO of Coastal Horizons; Tamiko Cory consumer in recovery; Larry Coley, consumer in recovery; and Tim Hall, Chair of the Substance Abuse Federation – (Attachment No. 6).

Barriers and challenges listed by the panelists included:

- Large number of Substance Abuse clients but only 22% of adult population eligible for Medicaid services
- Comprehensive continuum of services needed
- Difficulty accessing assistance through system
- Only 6% of funding goes to Substance Abuse
- Community provider care funding in rural communities
- Community provider capacity

- Funding for target and non-target populations
- No State funds for prevention services
- Limited pool of qualified professionals
- Not enough money for those who qualify for services under new Service Definitions
- Fear that agencies will fail under current structure

Recommendations included:

- Shortage of workforce – utilize Community Colleges and Universities
- Create category for high risk cases in target population to qualify for support treatment programs
- Need funding to build additional substance abuse treatment facilities in communities
- Insurance coverage parity
- Request $71 million as in MGT study

The committee requested data showing the number of children taken from homes due to substance abuse, the number of homes affected, data showing how long children are in foster care, and the cost associated.

After lunch, Senator Nesbitt said that staff was prepared to present information on Medicaid eligibility but asked that the information be presented at the March meeting. He then asked the panelists with comments regarding the role of consumers in reform to come forward. Panelists included: Dan Herr, Chair, Orange-Person-Chatham County (Consumer and Family Advisory Committee) CFAC – (Attachment No. 7); Jeff McLoud, Vice President, NC Mental Health Consumer's Organization – (Attachment No. 8); Carol Matthieu, Member of Rockingham County CFAC – (Attachment No. 9); and Ron Huber, Member, State CFAC.

Barriers and challenges listed by the panelists included:

- Transportation and housing needs not being met
- Meetings scheduled with Division and others not aligned with consumer availability
- Critical need for consumers to be able to share information and to help LMEs prioritize infrastructure and analyze feedback
- Difficulty communicating with Division, other CFAC's, other consumers and LOC
- LMEs need outline in roles and functions and clear guidance in how to support CFACs
- Stigmas need to be overcome

Recommendations included:

- Enact legislation ensuring consumer's basic needs
- Schedule meetings and locations that support attendance
- Establish 2 groups – one to gather information and one to focus on complex analysis
- Enhance communication and share information
- Authorize active involvement of consumers at decision making level
- Identify dollars for peer-run services

- Hold Division, LMEs, and providers accountable
- Assessment at local LME level to see if there is duplication or current need for committees and boards
- Staff CFAC with a competent LME level liaison
- Monitor potential conflicts of interest when recruiting for committees
- Make CFAC information available on county or LME website
- Need money and support to train consumers

Arey Grady, board member of the Neuse Center LME, gave comments regarding the role of the local board in reform. He said there were 3 challenges facing local boards. The first concern was the complexity of the system which is very difficult for board members to grasp – funding methodology, reimbursement mechanisms, and how the services are going to be delivered. He said more time could be spent on improving the lives of consumers if the system was not so complex. Mr. Grady suggested streamlining the system particularly in the fiscal area by emphasizing areas for local innovation and local programs. His second concern was communication and the flow of information. He said that receiving information first hand, particularly relating to policy changes and rationales would be helpful to board members and could in turn enable boards to give insight to the State. Mr. Grady's last concern was the lack of time board members had to digest large amounts of information, and translate that information into significant and far-reaching policy decisions for the local authorities.

Next, Flo Stein, Chief of Community Policy Program for the Division, spoke on the new Service Definitions for Substance Abuse Services. (See Attachment No. 10) She said that the new definitions would include a more credentialed workforce and generate more Medicaid funding that currently is not available in the system. Ms. Stein reviewed the SA service continuum of care offered now. She pointed out how some of the definitions changed for substance abuse as opposed to mental health. For Diagnostic Assessment and Community Support, services would be the same except that a qualified addiction specialist must be hired. Community Support will now allow continuing care to monitor a person's recovery. The Community Support Team offers first responders for crisis intervention, which is new to the system.

Ms. Stein reviewed specific definitions just for Substance Abuse starting with the components for Substance Abuse Intensive Out Patient Treatment (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT). She said that the same continuum was used for Child and Adolescent services except the Team would have to include a qualified addiction specialist. She said that the combination of old services and new services provide at least one service at every level of The American Society for Addiction Medicine (ASAM). However, every community does not have every one of these services because the funding is not available. She commented that because the Substance Abuse Block Grant is the major purchaser of these services, their target populations had to go on the list first. These groups are at highest risk and the most expensive. The list does not include all those who could benefit from prevention, intervention, or treatment. The Substance Abuse Block Grant supports prevention for children. She said the new definitions would have a positive impact on services but that there was an existing rule (IMD Exclusion) that would not allow the use of Medicaid facilities of more than 16 beds. The Division is going to do an analysis program by

program to see how much Medicaid was actually being earned to see if it would be better to have Medicaid only and State only facilities. Ms. Stein said that every call should be considered urgent or emergent in order to get individuals to community support or crisis services within 24 hours. Ms. Stein also said that individuals between the ages of 16 and 25 are the largest substance abusers.

Members were interested in the percentage of those with a positive treatment outcome. Ms. Stein said that the longer a person was in treatment the better. Community Support used well would make a difference since the new service definitions would allow professionals to go to the individual needing treatment. It is anticipated that 30%-40% could have a positive outcome. She was also asked if the outcomes were different between Out Patient treatment and In Patient care. Ms. Stein responded that if the hours of therapeutic treatment were the same, there should be a similar outcome. ASAM offers a way to look at the severity of the symptoms, the supports for recovery, the situation the person is bringing, the medical complications and determines where the person should be placed. She said that not all communities have the whole array of services but hopefully in time the services will be in place. She included that there is such a demand on the public system that it makes it difficult to meet the needs of all the people.

Ms. Stein was also asked if there was a limit on the number of times a person could go through treatment. She responded that Medicaid, in the new service definitions, put a limit of 30 days in any given year. It was suggested that since mental health parity was so important, that a representative from the insurance industry address the committee. Members also questioned how services would be delivered given the current funding problems. Mr. Moseley responded that the Department was currently working on the Expansion Budget to be presented to the Governor and that mental health was high on the priority list. Also, the Service Gap Study would identify over the next 5 years what services are needed to serve the people of North Carolina and what the cost of those services would be. He said preliminary findings would be presented to the committee in March with a further detailed report to be presented before the Short Session. Preliminary findings of the Financial Report that looks at how existing funding could be more equitably allocated and also looks at alternative financial strategies, will be presented in March with a more in depth report to be presented before the Short Session.

There being no further business, the meeting adjourned at 3:40 PM.

Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant